CORRESPONDENCE

Letter to the Editor

Dear Sir,

I would like to contribute to the Trans-Atlantic debate on the role of completion imaging following carotid artery endarterectomy in the May issue of the journal. I thought the arguments both for and against the use of completion angiography were well made, balanced and informative. However, I suspect that those who use or do not use completion imaging are unlikely to change their practise significantly given the similarity of results in terms of neurological events between those who use completion imaging and those who do not. As I see it, the major problem with both completion duplex ultrasound and angiography is that you need flowing blood through the common and internal carotid artery. As a routine tacker, both proximal and distal (and now of the external carotid in the light of the comments of Ricco, Schneider and Illuminati), a routine shunter and routine patcher (so my arteriotomy closure may take a little longer than some), the most frequent problem that I identify by routine angioscopy is residual, often firmly adherent, clot to the posterior wall of the endarterectomised surface, probably from vasa vasorum. This is despite aggressive use of heparinised saline flush prior to completion of the arteriotomy closure. One could just imagine how this clot might be missed and subsequently embolise to the cerebral circulation prior to performing completion duplex ultrasonography or angiography. As I have been taught, completion angioscopy does not require expensive equipment (I use a flexible ureteroscope), does not require additional manpower (sonographer or radiographer) and is very quick (less than 90 seconds).

S. Walker
Department of Vascular and Endovascular Surgery, Royal Hobart Hospital, Tasmania, Australia
Email-address: stuart.walker@dhhs.tas.gov.au

Available online 27 June 2013

http://dx.doi.org/10.1016/j.ejvs.2013.06.002